The outpatient corridor functions similar to the inpatient ancillary corridor. Any adjustment is based on a variation of actual revenues to budget which is a function of the outpatient budget statistics. A factor of 60 percent of excess revenues is passed on to the hospital to cover variable cost and to provide an incentive to increase outpatient modalities of care. There is no adjustment for decreased outpatient volume.

In all cases of the volume corridors, both the hospital's budgeted expenses and revenues may be affected. As volume increases, not only may the hospital retain the appropriate percentage of revenues collected but it may also adjust its budgeted expenses by a similar amount. Therefore, it can be readily seen that volume may cause a hospital to legitimately exceed its agreed upon budgeted revenues and expenses; and, in the aggregate, hospitals may exceed the MAXICAP should the reserve component of the MAXICAP be inadequate to cover the magnitude of the increased volume.

A related provision is that the program provides consideration for a possible change in patient mix. The patient mix adjustment is similar to that defined under Phase IV of ESP. However, after proving that a change in patient mix has occurred, the adjustment to negotiated expenses is negotiable between the hospital and Third Parties. The adjustment applies only to a change of patient mix requiring more intensity of care and not to a change requiring a decreased intensity. Again, as with the volume corridors, a hospital experiencing a change in patient mix may legitimately exceed its negotiated revenue and expense budgets; and, in the aggregate, hospitals may exceed the MAXICAP should the reserve factor be exceeded.

Major Contingency

The Rhode Island program also provides protection of all parties against unexpected and unforeseen events which may impact hospital expenses, such as: regulatory or statutory changes; "acts of God"; unusual increases in items like the unusual, unexpected rise in malpractice premiums two years ago; etc. Consideration for a major contingency may be requested by either the hospitals or the Third Parties, should the latter note an event which might cause a reduction in hospital expenses.

If a major contingency is granted, this again could cause a hospital to legitimately increase its budgeted revenues and expenses and, in the aggregate, may cause the MAXICAP to be exceeded should the reserve factor be exceeded. In addition, if the granting of a major contingency causes a problem whereby charges are lower than costs, a hospital may request a change in its charges and its prospective reimbursement rate may be changed.

Until now, this article has concerned itself with the major provisions of the program: the MAXICAP; health planning; hospital budgets, review, and analysis; budget negotiations; rate determination; and ways in which both the MAXICAP and negotiated budgets may be exceeded.

Within those sections, the responsibilities of hospitals and the Third Parties have been addressed. It is, however, appropriate to capsulize those responsibilities.

C. RESPONSIBILITIES OF THE PARTIES

The advent of Prospective Reimbursement brought increased responsibilities of the participants, both hospitals and the Third Parties. No longer could the parties operate under the ease of a retrospective cost reimbursement system.

1. Hospitals' Responsibility

For hospitals, prospective reimbursement demanded increased financial responsibility and expertise, including:

- Improved budgeting techniques and forecasting ability.
- Increased financial and statistical reporting.
- Additional budget management capabilities.
- Improved management efficiencies and operational productivity.
- Increased utilization of management engineering techniques, shared services, and other cost-saving techniques.

Not only did these requirements improve the hospitals' management responsibility for its budgeted expenses and financial controls, it also provided a major incentive to the institutions. If, as a result of improved budget management, a hospital can general savings within its negotiated budget, it is free to use those savings to further improve or expand its institutional services and programs, within the limits of the overall program.

2. Third Party Responsibility (State Budget Office/Blue Cross)

As the responsibilities of hospitals increased, so did the responsibilities of the Third Parties, including.

- Management of the statewide MAXICAP.
- Improved financial expertise and forecasting abilities.
- Expanded ability for budget review, analysis and budget negotiations.
- The ability to effectively monitor hospital financial performance.
- Better integration of the planning process.

The two most important responsibilities of the Third Parties are management of the

MAXICAP and monitoring of hospital financial performance. Prior to prospective reimbursement, the Third Parties' responsibility for controlling hospital expenses was limited. Additionally, management responsibility has increased the need to be able to monitor hospital financial performance on an ongoing basis. To accomplish this, a computerized budget monitoring system has been developed, utilizing the hospitals' financial and statistical reporting, to track hospital spending, volume, revenues, etc. during the year and identify and analyze reimbursement problems prior to the end of the fiscal year when it may be too late to correct.

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II. EXPERIENCE WITH THE CURRENT PROGRAM (1975-77)

The Parties are continuing to analyze the results of the present Prospective Reimbursement Program. However, a final analysis will not be available until year-end data for all three years of the Program has been gathered and verified. In addition, the official evaluation of the Program by SEARCH, under contract with the Office of Research and Statistics (ORS), will not be issued until after completion of the present year of operations. Despite this, some positive aspects of the Program can be demonstrated based on the initial data and analysis.

One distinguishing feature of the Program is the negotiation modality used for establishing the MAXICAP and for individual hospital budgets. Some critics have characterized this as being "cumbersome". It is true that the process of negotiations by its very nature requires some time and, that in the first and second years of the Program, negotiations were protracted. However, by the third year of the Program, the Parties had refined the negotiation process such that 1) the MAXICAP was resolved in only four negotiation sessions and one mediation session and 2) for FY 1976-77, over 75% of all hospital budgets were resolved in only one negotiation session during a sixty-day period. Overall, the Parties to the Program have found that the negotiation process has worked well in Rhode Island since these refinements. A comparison of some initial data from the Rhode Island experience bears this out.

In looking at the increases in cost per admission in Rhode Island compared with national and New England average increases, the Rhode Island experience is favorable in spite of the following factors:

1. The size of the State and the size of the greater metropolitan area of the City of Providence in relation to the State causes the average Rhode Island hospital to be located in a more urban setting than the average hospital nationally or in New England.

2. The average Rhode Island hospital is larger in size than the average hospital nationally or in New England.

3. Eight of the State's sixteen hospitals are affiliated with the Brown University Medical School. Therefore, the characteristic of university affiliation is more dominant in the average Rhode Island Hospital than in the average hospital nationally or in New England.

All of these factors have been correlated with higher hospital costs by many of the experts in the field. Such factors as size, urban setting, and university affiliations must be weighted and adjusted for in any comparison of "average" costs.

However, if one compares the average percentage increase in costs per admission, the Rhode Island Program has fared better than both national and New England averages. The following table compares these average increases:

TABLE I.
PERCENTAGE INCREASE IN COSTS
PER ADMISSION

(source A.H.A. Hospital Statistics Guide)

	FY 1975	FY 1976	FY 1977
Rhode Island	13.4%	12.3%	9.1% (1)
National	17.2% (2)	15.0% (3)	15.0% (3)
New England	16.9% (2)	15.0% (3)	15.0% (3)

(1) Based on negotiated FY 1977 budgets
(2) AHA Hospital Statistics Guide
(3) Based on latest government estimates

In all cases, Rhode Island has shown a smaller increase in costs per admission. Likewise, looking at comparisons of total operating expenses, the Rhode Island Program has shown a positive impact on controlling the growth in hospital expenses (which includes volume increases not reflected in per admission comparisons) when compared with what might have happened under a retrospective cost reimbursement system. Table II reflects this positive impact.

TABLE II

Comparison of Total Operating Expenses

	FY 1975	FY 1976	FY 1977	FY 1978
Orig. Maxicap Increment	13.85%	11.5%	10.5%	10.42%
Est. Adjusted Maxicap	14.3%	12.44%	11.03%	10.42%
Est. Adj. Maxicap Dollars	$200,148,775	$225,056,397	$249,958,387	$276,004,051
Est. Exp. Under Retrospective System	$203,442,298	$231,678,166	$253,672,121	$283,134,579
Est. Savings Prospective Versus Retrospective	$ 3,293,523	$ 6,621,769	$ 3,713,734	$ 7,130,528
Est. Medicaid Savings - 8.5% Participation	$ 279,949	$ 562,850	$ 315,667	$ 606,095

In all cases, had Rhode Island been on retrospective cost reimbursement or had the State experienced increases equivalent to national or New England averages, the Rhode Island community would have spent more on health care than was spent under Prospective Reimbursement. As it was, the State experienced substantial savings.

In addition to the dollar savings to the Rhode Island community, Prospective Reimbursement has had added positive aspects.

1. Through a system of utilization review mutually implemented by the Parties under the Program, Rhode Island has experienced a significant decrease in its length of stay. Table III shows this decrease.

Table III

Comparison of Average Length of Stay for Matched Patients(1)

	As of 9/30/74	As of 9/30/75	As of 3/31/76
Rhode Island	7.9	7.7	7.7
All U.S. Matched Patients	7.8	7.8	7.9
All Eastern Matched Patients	8.3	8.6	8.7

(1) Per summarization of CPHA Quarterly Length of Stay charts for all hospitals in Rhode Island.

As can be observed, during the course of the Prospective Reimbursement Program, the Rhode Island length of stay has dropped 0.2 days. In addition, it is 1.0 day below the Eastern average and, for the first time in history, below the national average.

2. Through budget negotiations, the Parties have mutually agreed to a significant reallocation of resources, including the closing of underutilized beds.

3. The impact of new and/or expanded medically oriented programs has been controlled by a linkage of an effective planning process to the reimbursement program. Since the inception of the present Program in 1974, the planning process has reviewed requests for over $6M in new or expanded programs. Only 48% of those requests or approximately $3M were approved. That represents only 1.2% of the total gross operating expenses of Rhode Island hospitals.

4. The level of financial management and overall management in hospital operations has improved tremendously.

5. More importantly, the Prospective Reimbursement Program has provided the Program participants and the Social Security Administration with significantly increased knowledge of hospital financing and reimbursement, as well as knowledge necessary for controlling the rise in hospital costs in the future.

In all, the Rhode Island Prospective Reimbursement Program has had a positive effect on controlling hospital costs. The final evaluation of the Program should bear this out.